4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-D-1

Methods and Standards for Determining Payment Rates for Non-State-Owned Nursing Facilities - (Excludes State-Owned Facilities)

I. Cost Finding and Reporting

All nursing facilities certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The Department adopted the Chart of Accounts for Long Term Care Facilities published by the American Nursing Home Association as the basic document for the LTC system July 1, 1975. The basic chart of accounts is updated and modified periodically and has been converted to a mandated computerized format. This standard computerized cost reporting mechanism must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for nursing facilities must be reported on the computerized format of the Financial and Statistical Report for Nursing Homes. These reports must be completed in accordance with generally accepted accounting principles using the accrual method of accounting and must be complete and accurate. Facilities are also required to submit a trial balance of the reporting entity as of the closing date of the reporting period. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating facility costs are reported semi-annually. The six-month reporting periods are January 1st through June 30th, and July 1st through December 31st.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked within 60 days following the end of the reporting period. The due dates are February

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28th for the December 31st closing date and August 31st for the June 30th closing date.

An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. Requests for an extension of the filing period are to be addressed in writing to the Director, Office of Audits, Research and Analysis, Bureau for Administration and Finance, Department of Health and Human Resources, Building 6, State Capitol Complex, Charleston, West Virginia 25305.

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the mandated (sixty days) filing period, where no extension has been granted to the facility or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subject to the following penalty provision: Facilities submitting cost reports after the beginning of the rate period; i.e., April 1st or October 1st, will receive rate increases effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected if resubmitted within 30 days after original rate notification. Only those corrections received by the Department within the 30-day period will be considered for rate revision. The Department will make rate revisions resultant from computational errors in the rate determination process.

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G. New Facilities - Projected Rates

A projected rate will be established for new facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. Each such facility on a projected rate must submit the calendar semi-annual cost reports during the projected rate period beginning with the first full six months operating experience in a reporting period.

H. Change of Ownership - Projected Rates

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility.

Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control. Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting projected rates.

Each such facility on a projected rate must submit the required semi-annual cost reports during the projected rate period beginning with the first 3 months operating experience in a reporting period.

I. Maintenance of Records

Financial and statistical records must be maintained by the facility to support and verify the information submitted on cost reports. Such records must be maintained for a minimum of five (5) years from the date of the report, and will be furnished upon request to the Department or Federal officials.

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The State agency will maintain cost reports for a minimum of seven (7) years from date of receipt.

II. Allowable Costs

Reimbursement for nursing facility services is limited to those costs required to deliver care to patients. These are facility operating costs, patient direct service costs, and costs for the physical setting.

Allowable Costs for Cost Centers

Cost center areas are standard services, mandated services, nursing services, and capital. A cost upper limit is developed for each cost center area and becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

1. Standard Services

Standard services are Dietary, Laundry/Housekeeping, Medical Records, and Administration. Cost standards for these services are computed from the current cost report; i.e., salaries, supplies and services as submitted by the facilities. Total allowable costs for all patients are arrayed assuming 100% occupancy; i.e., licensed beds times days, to establish a per patient day cost. The costs are then arrayed by bed range; i.e., 0-90 and 91 plus. Extremes are eliminated by including only those values falling within plus or minus one standard deviation. This establishes a cost average point (CAP), i.e., average cost per bed range. The CAP is then adjusted by a 90% occupancy level to establish the cost standard for each standard service department. These standard service departments' cost standards are then summed to obtain a cost ceiling that establishes the maximum allowable cost by bed range for the standard services.

2. Mandated Services

Mandated services are defined as Maintenance, Utilities, Taxes and Insurance, and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the percentile of allowable reported costs

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by facility classification as determined from the current cost report.

3. Nursing Services

Allowable costs and reimbursement for nursing services will be determined by the kind and amount of services needed by and being delivered to the patients, the staffing required to deliver the care, and the restorative and rehabilitative programs offered by the facility. Such determination will be based on the application of a minimum staffing pattern, and adjustments to reflect needs determined by case mix characteristics.

Monthly billing forms for services rendered to nursing home residents will include data directly derived from the computerized MDS+ for each resident, which will be used to determine composite case mix scores for each resident and for the facility. These case mix scores will measure the relative intensity and service need of the facility residents, and will comprise the basis for determining allowable adjustments to per diem staffing and costs required to deliver the kind and amount of services needed.

4. Cost of Capital

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). This value includes the necessary real property, and equipment associated with the actual use of the property as a long term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Nursing Home Standard, where appropriate. This valuation is the basis for capitalization to determine a per patient day cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

a. Cost Approach to Value

The value of a property is derived by estimating the replacement of reproduction cost of the improvements, deducting them from the estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for

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development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are Marshall Valuation Services and Boeckle Building Valuation Manual.

b. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method which involves an analysis of loss in value from the following sources:

(1) Physical deterioration; curable and incurable.
(2) Functional obsolescence; curable and incurable.
(3) Economic obsolescence.

The modified appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

c. Model Facility Standard

The Model Facility Standard is a composite of current regulations and criteria derived from several sources which include "Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities"--HHS Publication No. (HRS) 81-14500, and West Virginia Rules and Regulations, where appropriate. These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved patient

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care or cost effective measures which do not compromise patient care.

d. Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually prior to the October rate setting period. Updates may be performed at anytime during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate purposes. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index.

A copy of the facility appraisal report is furnished to the facility for its records.

5. Compensation

Compensation to be allowed must be reasonable for services that are necessary, related to patient care and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked and compensation must be documented and reported to all appropriate State and Federal authorities for income tax, Social Security, and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the bed ranges. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 2,080 hours per year worked in patient-related duties.

Compensation must include the total benefit paid for the services rendered; i.e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

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6. Administrators

Compensation for administrators who do not work full time will be proportionate to the total number of hours worked. This includes persons who hold administrative positions in more than one facility, as well as those who hold various other positions in the same or alternate facility.

7. Owners

Administrators/owners will be compensated for administrative duties performed. Where the costs of administrative services are allowed, additional services performed by the administrator and/or owner are considered rendered primarily to protect their investment and are not allowable.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative functions required to operate the facility where the facility has a full-time administrator and/or assistant administrator or where other full-time or part-time staff positions are filled. Owner includes any individual or organization with an equity interest in the facility operation and any member of such individual's family including spouse's family. Owner also includes all partners and all stockholders in the facility operation and partners and stockholders of organizations which have an equity interest in the facility.

8. Nonallowable Costs

Bad debt, charity, and courtesy allowances are not included as allowable costs. Other items of expense may be specified in the State agency regulations as nonallowable costs.

9. Purchase from Related Companies or Organizations

All related companies or organizations involved in any business transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records which describe the nature and extent of such business transactions.

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Cost for purchases of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less.

III. Rate Determination

Individual facility rates are established on a prospective basis, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, reconciliation of audit findings related to falsification or misreporting of costs, or incorrect reporting of census or costs. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report.

The reported costs are subject to desk audit and then converted to rates per patient day. Rates will be issued for six-month periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period.

A. Cost Adjustment

Reported facility costs are subject to review and analysis through desk audit. Adjustments are made to exclude nonallowable costs and by application of the agency's established cost standards using the following methodologies:

1. Standard Services

Reported allowable costs in the standard services area are compared against the cost ceiling for standard services using the appropriate bed range for the facility or facility class. If the allowable reported cost exceeds the cost ceiling, then the facility rate is limited to the ceiling.

2. Mandated Services

Mandated services are defined as Maintenance, Utilities, Taxes and Insurance, and Activities. Reported allowable costs for these services is fully recognized to the extent that it does not exceed the 90th percentile of allowable reported costs by facility classification as

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determined from the current cost report.

3. Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraised Value (SAV) methodology.

a. Capitalization Rate

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land, building and equipment.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate which may be changed semi-annually to reflect current money values in the mortgage market. This band of investment sets a 75:25 debt-service to equity ratio.

The yield on equity allowance (for proprietary facilities) is based on the average Medicare Trust Fund return on equity allowable during the cost reporting period.

The interest rate for the mortgage component is based on the Federal National Mortgage Association (FNMA) current at the time of the facility original indebtedness, modified by the use of the constant annual percent for non-profit facilities.

b. Capital Allowance

For proprietary facilities the per patient day capital allowance is determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value methodology.